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No. 87-818

IN THE
Supreme Court of the United States
OCTOBER TERM, 1987

KIP HAYES,
Petitioner,
v.
PRUDENTIAL INSURANCE COMPANY OF AMERICA,
NATIONAL LEAGUE OF POSTMASTERS
OF THE UNITED STATES, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF IN OPPOSITION FOR RESPONDENT NATIONAL LEAGUE OF POSTMASTERS

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QUESTION PRESENTED

Are state law causes of action based on: (1) breach of duty of fair dealing and good faith; (2) breach of fiduciary duty; and (3) breach of statutory duties, which relate to and are inconsistent with the terms of federal contracts authorized by the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8913, preempted by 5 U.S.C. § 8902(m)(1)?

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BRIEF IN OPPOSITION FOR RESPONDENT NATIONAL LEAGUE OF POSTMASTERS

STATUTE AND REGULATIONS INVOLVED

This case involves the Federal Employees Health Benefits Act of 1959, 5 U.S.C. §§ 8901-8913 ("FEHBA"), and its underlying regulations, which appear at 5 C.F.R. Part 890. The FEHBA is reprinted in Petitioner's Appendix ("Pet. App.") at D1-D56. Provisions of 5 C.F.R. Part 890 cited by respondent are reprinted in the appendix hereto, p. 1a-8a, *infra.*

STATEMENT OF THE CASE

We adopt the findings of fact contained in section II of the Court of Appeals' opinion. Pet. App. at B6-7.[1]

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[1] At Pet. 14 n.14, petitioner contends that "it is undisputed that petitioner is entitled to additional nursing care benefits which have

The Statutory and Regulatory System

The Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8913, is a comprehensive scheme to provide federal employees, retirees ("annuitants") and covered family members with government-subsidized health care benefits. Under FEHBA, the United States Office of Personnel Management ("OPM") contracts with qualified private organizations ("carriers") to create the various types of health benefits plans described in 5 U.S.C. § 8903.[2] The contracts are for a term of one year subject to renewal and are renegotiated annually. *See* § 8902 (a); 5 C.F.R. § 890.203. Each contract contains a detailed statement of the benefits offered and includes such maximums, limitations, exclusions, and other definitions of benefits as OPM considers necessary or desirable. *See* § 8902(d).

The federal government subsidizes the health benefits plans under the formula set forth in § 8906, which provides for a government contribution of 60% of the average cost of six selected plans. *See* § 8906(b)(1). The rates charged for the health benefits plans reflect the cost of the benefits provided, and are readjusted based on past experience and benefit adjustments. *See* § 8902(i).

OPM is responsible for providing information concerning the various health benefits plans to employees and annuitants. *See* § 8907. During the annual "open season," these individuals can switch from one plan to another, regardless of their present state of health or that of their covered family members. *See* §§ 8902(f), 8905(e); 5 C.F.R. § 890.301(d).

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not been paid . . . ." Petitioner fails to identify what those benefits are. In fact, none of the claims stated in his complaint were "undisputed," and all were rejected by the Court of Appeals.

[2] Section 8903 lists four types of health benefits plans: the service benefit plan, the indemnity benefit plan, employee organization plans and comprehensive medical plans. The Postmasters Benefit Plan ("Plan") is an employee organization plan open to all eligible federal employees, annuitants and their families.

FEHBA establishes a comprehensive framework by which OPM is empowered to regulate the federal health benefits program. OPM is authorized to prescribe minimum standards for carriers and to withdraw approval of their plans if the carriers fail properly to discharge their contractual obligations. 5 U.S.C. § 8902(e); 5 C.F.R. § 890.204. Under 5 U.S.C. § 8902(j), the carrier must agree to pay for or provide a health service or supply in an individual case if OPM determines that the enrollee or family member is entitled thereto under the terms of its contract with OPM.[3] To this end, OPM has established an administrative review process that allows any subscriber who believes that a carrier has erroneously denied a claim for benefits to appeal to OPM. 5 C.F.R. § 890.105. OPM also performs routine audits of each carrier to determine whether improper claims handling practices exist. *See* 5 U.S.C. § 8910 and 5 C.F.R. § 890.202(d). See also p. 6 n.5, *infra*.

REASONS FOR DENYING REVIEW

I. The Court of Appeals Correctly Followed Controlling Decisions of this Court

The decision below correctly held that FEHBA preempts both common-law and statutory state tort actions against FEHBA carriers. This result is fully in accord with two recent preemption decisions of this Court, *Pilot Life Insurance Co.* v. *Dedeaux*, 107 S. Ct. 1549 (1987), and *Allis-Chalmers Corp.* v. *Lueck*, 471 U.S. 202 (1985).

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[3] Section 8902(j) "does not grant OPM authority unilaterally to alter or amend the terms of the Plan; it requires only that the carrier comply with OPM's interpretation of the Plan." Pet. App. at B9. The Court of Appeals also upheld OPM's interpretation of § 8909(b)(2), which authorizes OPM to create a contingency reserve out of payments to a plan which can be used to expand benefits, as requiring carrier concurrence. *Id.*

FEHBA was amended in 1978 to add an express preemption provision, 5 U.S.C. § 8902(m)(1). That section provides:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

Petitioner argues that state tort claims based on the manner in which benefits are processed are outside the scope of § 8902(m)(1) because such claims do not pertain to coverage or benefits and do not conflict with the terms of FEHBA contracts. Pet. 21 n.17. Petitioner is wrong.

Petitioner's misunderstanding of preemption principles is best exemplified by his heavy reliance on *Cort* v. *Ash*, 422 U.S. 66 (1975). *Cort* v. *Ash* does not contain a single reference to, let alone discuss, "preemption." Instead, *Cort* sets out four factors that determine *whether a private right of action should be implied* under a statute that does not provide one expressly. 422 U.S. at 78-79. Petitioner's reliance on *Cort* can apparently be traced to *Massachusetts Mutual Life Insurance Co.* v. *Russell*, 473 U.S. 134 (1985), which determined on the basis of a *Cort* analysis that a private right of action should not be implied under section 409(a) of ERISA, 29 U.S.C. § 1109(a). But *Russell* likewise says nothing about preemption.

Petitioner's confusion is not limited to his misuse of *Cort* v. *Ash*. He likewise misunderstands other decisions of this Court that sustain preemption under federal contracts indistinguishable from the FEHBA contract from which petitioner's claims arise.

Pilot Life Insurance Co. v. *Dedeaux*, 107 S. Ct. 1549 (1987), disposes of petitioner's claim that § 8902(m)(1) must be construed narrowly. In *Pilot Life*, this Court held that state tort claims based on improper processing of benefits were preempted under ERISA's express preemption clause, which preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

Pilot Life followed *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985), and *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983), which decided that " '[t]he phrase "relate to" was given its broad common-sense meaning, such that a state law "relate[s] to" a benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan.' " *See* 107 S. Ct. at 1553. *Pilot Life* held that the state tort claims in that suit related to an employee benefit plan, and were not saved from preemption by ERISA's saving clause, which excepts from preemption those state laws that "regulate insurance." *Id.* at 1553-55.[4]

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[4] To reach this conclusion, the Court examined three criteria used to determine whether a practice regulated the business of insurance for the purposes of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. Applying those criteria, the Court held that the Mississippi law of bad faith does not regulate insurance, since that law "developed from general principles of tort and contract law available in any Mississipi breach of contract case." *Id.* at 1555.

Petitioner maintains throughout his petition that Congress did not intend that FEHBA "emasculate" the rights of states to regulate the business of insurance authorized by the McCarran-Ferguson Act. To the extent that petitioner's argument rests on the premise that common-law state tort claims regulate the business of insurance, *Pilot Life* has explicitly rejected that argument. Moreover, even if the generalities of the McCarran-Ferguson Act were otherwise applicable, it is quite clear that FEHBA contracts are not *insurance* contracts. FEHBA's relationship to the McCarran-Ferguson Act is explicitly discussed in a letter written by Alan K. Campbell, then-chairman of the Civil Service Commission, to Senator Ribicoff, in which he explained why the preemption provi-

The Ninth Circuit recognized correctly that under *Pilot Life*, "Hayes' state law claims are preempted by the FEHBA." Pet. App. at B13. Not only is ERISA's preemption provision "similar to section 8902(m)(1) of the FEHBA," but "the state claims [in *Pilot Life*] were preempted despite a saving clause which has no counterpart in the FEHBA." *Id.* (citation omitted).[5]

The only significant difference between FEHBA's and ERISA's preemption provisions is that, with the exception of laws regulating insurance, ERISA preempts all state laws relating to ERISA plans, while FEHBA preempts state laws that are inconsistent with FEHBA contracts. Insofar as petitioner contends that his state tort claims escape preemption because they are consistent

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sion was necessary. He therein quoted the opinion of the Commission's General Counsel:

> The McCarran-Ferguson Act by its terms and the interpretation of the courts in no way diminishes the supremacy of the Federal Employees Health Benefits Act over State laws. If the Commission is to have a free hand it needs to administer the Federal Employees Health Benefits Act, no other conclusion can be reached.

S. Rep. No. 903, 95th Cong., 2d Sess. 8 (1978).

[5] Petitioner attempts to escape the conclusion reached in *Pilot Life* by claiming that FEHBA, unlike ERISA, lacks a detailed and comprehensive enforcement mechanism. Pet. 27. Yet 5 C.F.R. § 890.105 not only provides for administrative review of denied claims, but OPM's determination that a claim is covered under a FEHBA plan is binding on the carrier by statute. *See* § 8902(j). If the enrollee disagrees with OPM, the regulations provide that the carrier can be sued "to recover on a claim," and that OPM can be sued "to review . . . a decision made by OPM." § 890.107. OPM also prescribes minimum standards for carriers, § 8902(e), and performs routine audits on each carrier under § 8910 and 5 C.F.R. § 890.202(d). Finally, under 5 C.F.R. § 890.204, OPM has the authority to withdraw approval of a plan if the carrier does not properly discharge its contract obligations. Thus, petitioner's contention that state tort claims provide the only means for enrollees to enforce their rights under FEHBA is without foundation.

with FEHBA plans, that issue is governed by *Allis-Chalmers Corp.* v. *Lueck*, 471 U.S. 202 (1985).

In *Lueck*, an employee sought to recover for the alleged bad faith manner in which his disability claim was processed under a collective bargaining agreement pursuant to § 301 of the Labor Management Relations Act, 29 U.S.C. § 1859(a). These agreements are governed by federal law because the "subject matter of § 301(a) 'is peculiarly one that calls for uniform law.'" 471 U.S. at 210 (quoting *Teamsters* v. *Lucas Flour Co.*, 369 U.S. 95, 103 (1962)). The question before the Court was whether the tort of bad faith was independent of the contract or "whether evaluation of the tort claim is inextricably intertwined with consideration of the terms of the . . . contract." *Id.* at 213. Reasoning that the duty to act in good faith, like the explicit contractual duty to pay, "depends upon the terms of the agreement between the parties, both are tightly bound with questions of contract interpretation that must be left to federal law." *Id.* at 216. Thus, since "Congress has mandated that federal law govern the meaning given [§ 301] contract terms," this Court held that state tort claims, which "purport[] to give life to these terms in a different environment," are preempted. *Id.* at 218-19.

FEHBA contracts are federal contracts negotiated between OPM and various carriers pursuant to 5 U.S.C. § 8902 to provide health benefits to federal employees as a term and condition of their employment. *Christiansen* v. *National Savings & Trust Co.*, 683 F.2d 520, 530-32 (D.C. Cir. 1982). The interpretation of FEHBA contracts is governed exclusively by federal law. *Tackitt* v. *Prudential Insurance Co. of America*, 758 F.2d 1572, 1575 (11th Cir. 1985). *But see Howard* v. *Group Hospital Service*, 739 F.2d 1508 (10th Cir. 1984), discussed at pp. 9-11, *infra*. Moreover, FEHBA contracts are federal procurement contracts which are "governed by federal, not state, law." *Delancy* v. *National Post Office*

Mail Handlers, No. 84-0695, slip op. at 8 (M.D. Pa. June 25, 1985). *See also United States* v. *Allegheny County*, 322 U.S. 174, 183 (1944).

Like § 301 agreements, the subject matter of FEHBA contracts requires that they be governed by uniform federal law: "[T]he policy underlying section 8902(m)(1) is to ensure uniformity in the administration of FEHBA benefits. *See* H.R. Rep. No. 282, 95th Cong., 1st Sess. 1, 4 (1977)." Pet. App. at B12. Following *Lueck*, the Court of Appeals held that petitioner's state tort claims were preempted because "[t]ort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract." Pet. App. at B13.

As in *Lueck*, petitioner's state tort claims, which "invariably expand" a carrier's financial obligations under its FEHBA contract, and which will increase the premiums paid by the government and the enrollees, "are inconsistent with the Plan and hence, preempted under § 8902(m)(1)." *Id. See also Blue Cross & Blue Shield of Florida, Inc.* v. *Department of Banking & Finance*, 791 F.2d 1501 (11th Cir. 1986); *Myers* v. *United States*, 767 F.2d 1072, 1074 (4th Cir. 1985).

II. There is no conflict of decisions warranting review

As we have seen, the court below rejected petitioner's state law claims on the ground that they are preempted by 5 U.S.C. § 8902(m)(1). That holding is in accord with the decisions of two other Circuits. *Blue Cross & Blue Shield of Florida, Inc.* v. *Department of Banking & Finance*, 791 F.2d 1501 (11th Cir. 1986), *Myers* v. *United States*, 767 F.2d 1072 (4th Cir. 1985).[6] But peti-

[6] Contrary to the assertion at Pet. 16, the Eleventh Circuit's decision in *Blue Cross & Blue Shield* has a full discussion of the legislative history of § 8902(m)(1). See 791 F.2d at 1504-05. The assertion that there is a "distinct lack of remedies available to FEHBA plan participants under federal law" (Pet. 16) is simply false. See p. 6, n.5, *supra*.

tioner contends that this interpretation conflicts with the decision of the Tenth Circuit in *Howard* v. *Group Hospital Service*, 739 F.2d 1508. Pet. 15-20. Petitioner errs because the Tenth Circuit said nothing which supports petitioner's reading of § 8902(m)(1).

The *Howard* opinion's discussion of § 8902(m)(1) is confined to a single footnote which, after quoting that provision, states in its entirety: "There is no indication that any law of Oklahoma conflicts with the medical necessity or any other provision of the Blue Cross contract." 739 F.2d at 1510, n.1. This is certainly not a holding that § 8902(m)(1) does not preempt federal law where there is a conflict.[7] Moreover, it is doubtful whether *Howard*'s sparse observation concerning § 8902(m)(1) would have had a precedential value in the Tenth Circuit even absent subsequent guidance from this Court. In any event, the intervening decisions in *Pilot Life* and *Lueck*, *supra*, establish that no state law claims may be based on a contract under FEHBA. See pp. 5-8, *supra*. Thus, to the extent that *Howard* holds to the contrary under § 8902(m)(1) or otherwise, it can no longer be deemed good law anywhere and cannot give rise to a conflict calling for resolution by this Court.

Since *Howard* dealt with § 8902(m)(1) only in a footnote, petitioner indulges in hyperbole, at best, when he asserts that "the *Howard* court sets forth a thoughtful and well-reasoned basis for concluding that § 8902(m)(1) does not preempt state law actions for recovery on

[7] On the contrary, to the extent that the foregoing can be taken as an interpretation of the federal statute, it implies—and we put it no higher—that § 8902(m)(1) would preempt state law to the extent of any conflict. Such is the case here. If petitioner's claim for breach of contract were to be sustained under California law, the law of California would, to that extent, conflict with the contract as it has been interpreted by the court below in this case (Pet. App. at B10-11). Additionally, *Allis-Chalmers* v. *Lueck*, *supra*, establishes that the noncontractual claims which petitioner asserts under California law would conflict with FEHBA.

individual claims under FEHBA insurance plans." (Pet. 16.) In fact, the *Howard* opinion discussed an entirely different question, whether—as the defendants there urged in reliance on *Clearfield Trust Co.* v. *United States*, 318 U.S. 363 (1943)—"because a government agency is a party to the FEP contract, federal law should apply to the interpretation of the medical necessity provision to promote uniformity of decision and interpretation of the contract." 739 F.2d at 1509. The *Howard* court held that state law applies, pointing to cases such as *Miree* v. *DeKalb County*, 433 U.S. 25 (1977), which had distinguished *Clearfield*. In so concluding, the *Howard* court erred, as we show briefly in the margin.[8] But for present purposes, the essential point is that the petition does not challenge that portion of the Court of Appeals' opinion which rejected his breach-of-contract claims. Pet. App. at B8-11. For, as one California Appellate Court recently observed, "[t]he analysis in *Howard* was limited to the contract claim; there was no reference to preemption in the majority opinion, and, as the concurring opinion stated, the existence of a federal preemption defense would be insufficient to invoke the existence of removal

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[8] The Tenth Circuit stated—correctly, we think—that under *Clearfield* and *Miree*, "when the federal government has an articulable interest in the outcome of a dispute, federal law governs." 739 F.2d at 1510. It acknowledged that "if diverse resolutions of a controversy would frustrate the operations of a federal program, * * * or have some direct effect on the United States or its treasury, then federal law applies." *Id.* at 1510-11. But the court determined that state law applies: "We fail to see how various state court adjudications of FEP benefits claims will frustrate the operation of that program or conflict with a specific national policy." *Id.* at 1511. This characterization was clearly wrong because of the importance of nationwide uniformity, and because state law rules which are more generous than federal law would provide increased premiums, which must be paid not only by the enrollees, but by the government. See p. 8, *supra*. Petitioner himself recognizes "the express Congressional purpose of providing federal employees with medical insurance benefits at the lowest possible cost to the government and to the employees." (Pet. 19.)

jurisdiction." *Hartenstine* v. *Superior Court*, 196 Cal. App. 3d 206, 241 Cal. Rptr. 756, 764 (1987).

Hartenstine squarely held that § 8902(m)(1) preempts state tort claims based on bad faith and violation of the California Insurance Code. 241 Cal. Rptr. at 763-66. Petitioner fails to mention *Hartenstine* although he contends, in his final argument, that the decision below conflicts with *Fields* v. *Blue Shield of California*, 163 Cal. App. 3d 570, 209 Cal. Rptr. 781 (1985). Of course, a conflict between a state intermediate court and a federal court of appeals is not sufficient under Rule 17 to justify the grant of certiorari. This is all the more true in light of *Hartenstine*, since the California Supreme Court is the proper forum, in the first instance, to resolve the controversy between two California appellate courts as to the preemptive effect of § 8902(m)(1) on California law. Moreover, *Fields*, like the Tenth Circuit's decision in *Howard*, has been overtaken by *Lueck* and *Pilot Life*.

The short of the matter is that petitioner's state law claims are preempted by § 8902(m)(1), and there is no viable conflict of decisions with respect to the interpretation of that provision.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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APPENDIX

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PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

§ 890.105 Filing claims for payment or service.

(a) *General.* Each health benefits plan adjudicates claims filed under the plan. An enrollee must initially submit all claims to the health benefits plan in which he or she is enrolled. If the plan denies a claim, the enrollee may ask the plan to reconsider the denial. If the plan affirms its denial or fails to respond as required by paragraph (b) of this section, the enrollee may ask OPM to review the claim.

(b) *Timeframes for reconsidering a claim.* (1) The plan must reconsider its initial denial of a claim (or a portion of a claim) when an enrollee submits a written request for reconsideration to the plan within 1 year after the date of the notice to the enrollee that the claim was denied.

(2) Within 30 days after the date of receipt of a timely-filed request for reconsideration, the plan must (i) affirm the denial in writing to the enrollee; (ii) pay the bill or provide the service; or (iii) request from the enrollee or provider additional information needed to make a decision on the claim. If a plan requests additional information from a provider, it must simultaneously notify the enrollee of the information requested. When additional information is requested, the plan must, within 30 days after the date the information is received, affirm the denial in writing to the enrollee or pay the bill or provide the service. If the enrollee or the provider does not respond within 60 days after the date of the plan's notice requesting additional information, the plan will make its decision based on the evidence it has. The plan must then send written notice to the enrollee of its decision on the claim. If the plan fails to act within 30

days after the enrollee's request for reconsideration or the plan's receipt of additional information, the enrollee may request OPM review as provided in paragraph (b) (3) of this section.

(3) If a plan either affirms its denial of a claim or fails to respond to an enrollee's written request for reconsideration within 30 days after the date it receives the request or within 30 days after the date it receives additional information requested, the enrollee may write to OPM and request that OPM review the plan's decision. The enrollee must submit the request for OPM review within the timeframes specified in paragraph (d) (1) of this section.

(4) A plan may extend the time limit for an enrollee's submission of additional information to the plan when the enrollee shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) *Information required to process requests for reconsideration.* (1) When requesting the plan to reconsider a claim, the enrollee must put the request in writing and give the reason the claim should not have been denied.

(2) If the plan needs additional information from the enrollee to make a decision, it must (i) specifically identify the information needed; (ii) state the reason the information is required to make a decision on the claim; (iii) specify the timeframe (60 days after the date of the plan's request) for submitting the information; and (iv) state the consequences of failure to respond within the time limit specified, as set out in paragraph (b) (2) of this section.

(3) If the plan affirms the initial denial, it must provide written notice to the enrollee. This notice must inform the enrollee of (i) the specific and detailed reasons

for the denial; (ii) the enrollee's right to request a review by OPM; and (iii) the requirement that requests for OPM review must be received within 90 days after the date of the plan's notice of denial.

(d) *OPM review.* (1) OPM must accept a request for review that is received (i) within 90 days after the date of the plan's notice to the enrollee that the denial was affirmed; or (ii) if the plan fails to respond to the enrollee as provided in paragraph (b)(2) of this section, within 120 days after the date of the enrollee's timely request for reconsideration by the plan or the date the enrollee is notified that the plan is requesting additional information. OPM may extend the time limit for an enrollee's request for OPM review when the enrollee shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by a plan, OPM may (i) request that the enrollee submit additional information; (ii) obtain an advisory opinion from an independent physician; or (iii) obtain any other information as may in its judgment be required to make a determination. (OPM's request for an advisory opinion will not identify the enrollee or patient, the plan, or any medical institutions or physicians involved in the claim.)

(3) When OPM requests information from a plan, the plan must release the information within 30 days after the date of OPM's written request unless a different timeframe is specified by OPM in its request. Any evidence submitted by the enrollee or by the plan for review of the denied claim will be held as privileged information and will be reviewed only by persons having official need to see it.

(4) Within 30 days after receipt of the necessary evidence, OPM will give a written notice of its decision to the enrollee and the plan.

[51 FR 18564, May 21, 1986]

§ 890.107 Legal actions.

An action to compel enrollment of an employee or annuitant not excluded by § 890.102(c) should be brought against the employing office. An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan. An action to review the legality of OPM's regulations under this part or of a decision made by OPM should be brought against the Office of Personnel Management, Washington, DC 20415. However, an enrollee's dispute of an OPM decision solely because it concurs in a health plan carrier's denial of a claim is not a challenge to the legality of OPM's decision. Therefore, any subsequent litigation to recover on the claim should be brought against the carrier, not against OPM.

[51 FR 18565, May 21, 1986]

§ 890.202 Minimum standards for health benefits carriers.

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(d) It must permit representatives of OPM and of the General Accounting Office to audit and examine its records and accounts which pertain, directly or indirectly, to the plan at such reasonable times and places as may be designated by OPM or the General Accounting Office.

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§ 890.203 Application for approval of, and proposal of amendments to, health benefit plans.

(a)(1) Comprehensive medical plans should apply for approval by writing to the Office of Personnel Manage-

ment, Washington, DC 20415. Application letters must be accompanied by any descriptive material, financial data, or other documentation required by OPM. Plans must submit the letter and attachments in the OPM-specified format by January 31 of the year preceding the contract year. For contract year 1986 only, the letter application and attachments may be submitted as late as March 6, 1985. Plans must submit evidence demonstrating they meet all requirements for approval by March 31 of the year preceding the contract year. Plans that miss either deadline cannot be considered for participation in the next contract year. All newly approved plans must submit benefit and rate proposals to OPM by May 31 of the year preceding the contract year to be considered for participation in that contract year. OPM may make counterproposals at any time.

(2) Application for approval of employee organization plans may be made by letter to the Office of Personnel Management, Washington, DC 20415, after December 31, 1978, and before January 1, 1980. This letter application is to be accompanied by such descriptive material, financial data and documentations as OPM may require in its review process and in the format specified by OPM. Participation of an approved plan becomes effective on the January 1 which is (i) at least 9 months after OPM receives the application and (ii) at least 6 months after OPM receives all evidence to demonstrate that the plan has met all requirements for approval.

(b) Changes in rates and benefits for approved health benefits plans shall be considered at the discretion of the Director of OPM. If the Director of OPM determines that it is beneficial to enrollees and the Federal Employees Health Benefits Program to invite health plan benefit and/or rate changes for a given contract period, a "call letter" shall be issued to the carrier approximately 9 months prior to the expiration of the current contract period. Any proposal for change shall be in writing,

specifically describe the change proposed, and be signed by an authorized official of the carrier. OPM will review any requested proposal for change and will notify the carrier of its decision to accept or reject the change. OPM may make a counter proposal or at any time propose changes on its own motion. Benefits changes and rate proposals, when requested by OPM, shall be submitted not less than 7 months before the expiration of the then current contract period, unless the Director of OPM determines that a later date is acceptable. The negotiation period shall begin approximately 7 months before the expiration of the current contract period, and OPM shall seek to complete all benefit and rate negotiations no later than 3 months preceding the contract period to which they will apply.

[37 FR 20668, Oct. 3, 1972, as amended at 41 FR 40090, Sept. 17, 1976; 43 FR 52461, Nov. 13, 1978; 48 FR 16232, Apr. 15, 1983; 50 FR 8315, Feb. 28, 1985]

§ 890.204 Withdrawal of approval of health benefits plans.

(a) The Director may withdraw his or her approval of a health benefit plan or carrier.

(b) Before withdrawing approval, the Director shall cause to be sent, by certified mail, a notice of the carrier stating that he or she intends to withdraw OPM approval of a health benefits plan therefor. The carrier is entitled to reply in writing within 15 days of its receipt of the notice, stating the reasons why approval should not be withdrawn.

(c) On receipt of the reply, or in the absence of a timely reply, the Director shall set a time and place for hearing. The Director shall conduct the hearing or designate a representative to do so, unless the carrier waives hearing. The carrier shall be given notice thereof, by certified mail, at least 15 days in advance of the hearing.

The carrier is entitled to appear by representative and present oral and written evidence and argument in opposition to the proposed action.

(d) The Director shall make his or her decision on the record and communicate it to the carrier by certified mail. The Director may set a future effective date for withdrawal of his or her approval.

(e) The Director, in his or her discretion, may reinstate approval of a finding that the reasons for withdrawing approval no longer exist.

[33 FR 12510, Sept. 4, 1968. Redesignated at 49 FR 1046, Jan. 9, 1984]

§ 890.301 Opportunities to register to enroll and change enrollment

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(d) *Open season.* (1) An open season will be held from the Monday of the second full workweek in November through the Friday of the first full workweek in December in any year—

(i) That precedes a year during which the rates or benefits of any health benefits plan in the program will change; or

(ii) That precedes a year during which a newly-approved plan will begin participation in the Program; or

(iii) At the end of which an existing health benefits plan will cease to participate in the Program.

(2) The Director of the Office of Personnel Management may modify the dates specified in this paragraph or announce additional open seasons. Announcements of open seasons will be made by OPM in Federal Personnel Manual (FPM) Bulletins.

(3) During open season—

(i) An eligible unenrolled employee may register to be enrolled.

(ii) An enrolled employee, annuitant, or former spouse may change to another plan, another option, or from self alone to self and family, or may make any combination of these changes.

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§ 890.302 Coverage of family members.

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(d) *Child incapable of self-support.* When an employee, annuitant, or former spouse enrolls for a family which includes a child who has become 22 years of age and is incapable of self-support, the employing office will require such enrollee to submit a physician's certificate verifying the child's disability. The certificate must—

(1) State that the child is incapable of self-support because of a physical or mental disability that existed before the child became 22 years of age and that can be expected to continue for more than 1 year;

(2) Include a statement of the name of the child, the nature of the disability, the period of time it has existed, and its probable future course and duration; and

(3) Be signed by the physician and show the physician's office address. The employing office will require the employee, annuitant, or former spouse to submit the certificate on or before the date the child becomes 22 years of age. However, the employing office may accept otherwise satisfactory evidence of incapacity not timely filed.

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